U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 04 October 2006

In the Matter of

D.R.S.,

Claimant,

v. Case No. 2004-BLA-06275

J & S COLLIERIES, INC.
(dba J&M Trucking Jackie Dean Justice),

Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Party-In-Interest.

Appearances:	Joseph E. Wolfe, Esq. Wolfe, Williams & Rutherford For the Claimant	Lois A. Kitts, Esq. Baird & Baird, P.S.C. For the Employer
Before:	William S. Colwell Administrative Law Judge	

DECISION and ORDER DENYING BENEFITS

INTRODUCTION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act (the "Act"), 30 U.S.C. §§ 901 *et. seq*. Benefits under the Act are awarded to coal

miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners who were totally disabled due to pneumoconiosis at the time of their deaths (for claims filed prior to January 1, 1982), or whose death was due to pneumoconiosis.

Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation. The Act and its implementing regulations define pneumoconiosis as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of employment in the Nation's coal mines. 30 U.S.C. § 902(b); 20 C.F.R. § 718.201 (2004). In this case, the Claimant, D. R. S., alleges that he is totally disabled by pneumoconiosis.

The Department of Labor has issued regulations governing the adjudication of claims for benefits arising under the Black Lung Benefits Act at Title 20 of the Code of Federal Regulations. The procedures to be followed and standards applied in filing, processing, adjudicating, and paying claims, are set forth at 20 C.F.R. Part 725, while the standards for determining whether a coal miner is totally disabled due to pneumoconiosis are set forth at 20 C.F.R. Part 718.

On June 23, 2005, Claimant, by counsel, filed a Motion for Hearing on the Record. Employer did not object to the submission of the claim on the record. I find that Claimant has waived his right to appear at a formal hearing. 20 C.F.R. § 725.461. Pursuant to Order dated February 3, 2006, the undersigned established a schedule for the post-hearing submissions of evidence and updated evidence summary forms, and admitted into the record Director's Exhibits 1-32, Administrative Law Judge's Exhibits 1-3 and Employer's Exhibits 1-8.[1] In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence.

PROCEDURAL HISTORY

Claimant's filed this claim for benefits under the Act on November 1, 2002. DX-2. On October 9, 2003, after the initial development of the record, the District Director issued a *Schedule for the Submission of Additional Evidence*. DX-20. The District Director concluded that the Claimant would be entitled to benefits if a decision on the merits were issued at that time, and also determined that J & S Collieries had been

[1] On August 2, 2005, Claimant requested to have the chest x-ray taken by Rosenberg reread. The Employer objected to the admission of this rereading, citing the fact that Claimant had submitted on the record in waiving a formal hearing in this claim. This matter was taken up in a telephone conference call on February 2, 2006, and Claimant's request for the submission of the x-ray rereading was denied.

correctly named as the responsible operator. On January 20, 2004, the District Director issued a *Proposed Decision and Order - Award of Benefits -- Responsible Operator*. DX-23. By letters dated January 27 and March 1, 2004, the Employer by counsel and the carrier requested a formal hearing. DX-24 & DX-28. Pursuant to these requests, this claim was referred on April 27, 2004 to the Office of Administrative Law Judges for a formal hearing as noted above. DX-30.

APPLICABLE STANDARDS

Because Claimant filed this application for benefits after March 31, 1980, the regulations set forth at Part 718 apply. *Lane v. Union Carbide Corp*., 105 F.3d 166, 170 (4th Cir. 1997); *Saginaw Mining Co. v. Ferda*, 879 F.2d 198, 204, 12 B.L.R. 2-376 (6th Cir.1989). This claim is governed by the law of the United States Court of Appeals for the Sixth Circuit, because Claimant was last employed in the coal industry in the Commonwealth of Kentucky, within the territorial jurisdiction of that court. *Danko v. Director*, *OWCP*, 846 F.2d 366, 368, 11 B.L.R. 2-157 (6th Cir. 1988). *See Broyles v. Director*, *OWCP*, 143 F.3d 1348, 1349, 21 B.L.R. 2-369 (10th Cir. 1998); *Kopp v. Director*, *OWCP*, 877 F.2d 307, 12 B.L.R. 2-299 (4th Cir. 1989); *Shupe v. Director*, *OWCP*, 12 B.L.R. 1-200 (1989) (*en banc*).

In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is a substantial contributor to his total respiratory disability. 20 C.F.R. §§ 718.1, 718.202, 718.203 and 718.204 (2004). *See Mullins Coal Co., Inc. of Virginia v. Director, OWCP*, 484 U.S. 135, 141, 11 B.L.R. 2-1 (1987); *Jericol Mining, Inc. v. Napier*, 301 F.3d 703, 708, 22 B.L.R. 2-537 (6th Cir. 2002), *cert. denied*, 538 U.S. 906 (2003).

The Claimant has the burden of proving each element of entitlement to benefits by a preponderance of the evidence. *Director*, *OWCP v. Greenwich Collieries* [*Ondecko*], 512 U.S. 267, 18 B.L.R. 2A-1 (1994), *aff'g* . *Greenwich Collieries v. Director*, *OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993). The failure to prove any requisite element precludes a finding of entitlement. *Anderson v. Valley Camp of Utah*, *Inc*., 12 B.L.R. 1-111 (1989); *Perry v. Director*, *OWCP*, 9 B.L.R. 1-1 (1986) (*en banc*).

ISSUES

The following issues are before the undersigned for adjudication:

1. Whether this claim was timely filed.
2. Whether Claimant engaged in coal mine employment after 1969, and completed one year of employment with this Employer.

3. The length of Claimant's qualifying coal mine employment.
4. Whether the Claimant has pneumoconiosis as defined in the Act and the regulations and whether his pneumoconiosis arose out of coal mine employment.
5. Whether the Claimant is totally disabled.
6. Whether any total respiratory disability is due to pneumoconiosis.
7. Whether J&S Collieries is the correctly named responsible operator.
8. Whether employer has secured adequate insurance.

See DX-30.[2]

FINDINGS OF FACT

BACKGROUND

In his employment history form, DX-3, Claimant asserted that he began his coal mine employment with Shell Coal Company, apparently in 1973. He represented that he then worked for Canada Coal from 1978 until 1992.[3] This was followed by two years at Husky Coal from 1992 until 1994, and then employment "about a year" with J & S Collieries from 1994 until Claimant left mining in 1995. DX-3. In a more detailed description of coal mine work, Claimant stated that he operated as a miner from January, 1974 until June 1995. DX-4. In an affidavit dated June 13, 2003, Claimant represented that he worked for J & S Collieries from 1993 until 1994. However, the Social Security Administration earnings statement reflects employment with J & S Collieries in 1994, with earnings of $22,443.49, and 1995, when Claimant earned $12,173.09. There is no employment with Husky Coal in 1994. DX-7.

Based on the above-listed evidence and the District Director's analysis at DX 20 and DX 23, and the documentation at DX 6, 7, and 8, I find the evidence supports the District Director's finding of 20 years of coal mine employment.

In a description of coal mine work, Claimant described his last job as a "miner operator" as follows: "cut coal, miner biting, rock dusted, scoops, miner helper, bolt machine, shuttle car, [and] hung line curtains." DX-4.

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[2] Employer has also challenged the validity of the Secretary's regulations, as amended. This issue has been preserved for appeal.

[3] Claimant received an occupational disease award from the Commonwealth of Kentucky against Canada Coal in 1991. *See* DX-8 & DX-9.

MEDICAL EVIDENCE

Chest X-Rays

Ex. No.	X-Ray/Reading Dates	Physician	Credentials	Interpretation
DX-11	03-12-03/03-12-03	L. K. West	B/BCR	quality 1, negative
DX-12	03-12-03/04-01-03	P. Barrett	B/BCR	quality 1
EX-5	03-12-03/05-16-05	A. Poulos	B/BCR	quality 1, 0/0
EX-1	06-17-04/06-17-04	D. Rosenberg	B/BCR	quality 1, 0/0
EX-3	12-04-03/12-30-03[4]	G. Fino	B	quality 1, negative

Pulmonary Function Test Evidence

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The quality standards for pulmonary function studies are set forth at 20 C.F.R. § 718.103 (2004) and Appendix B.

The following chart summarizes the results of the pulmonary function studies available in connection with this claim. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 C.F.R. § 718.204(b)(2)(i) (2004).[5] *See Grundy Mining Co. v. Flynn*, 353 F.3d 467, 471 n. 1, (6th Cir. 2003);

[4] The date of the x-ray included in Employer's Exhibit 3 is illegible. The Employer's evidence chart indicates that this film is dated December 4, 2003, the date of Dr. Fino's examination of Claimant. Dr. Fino signed the x-ray report on December 30, 2003, however.

[5] Assessment of the pulmonary function study results is dependent on the Claimant's height, which has been measured at 66, 66.3 and 67 inches. I find Claimant's height to be 66.4 inches for purposes of evaluating the pulmonary function studies. *See*

Director, OWCP v. Siwiec, 894 F.2d 635, 637 n. 5, 13 B.L.R. 2-259 (3d Cir. 1990).

Ex. No.	Date	Age	HT.	FEV_1	FVC	MVV	FEV_1/FVC	Qualify
DX-11	03-12-03	49	67"	2.33	3.40	44.3		No

Dr. R. V. Mettu administered this test. He noted "good" cooperation and comprehension in its performance, and concluded that the results showed a "[m]ild obstructive airway disease with decreased MVV." Tracings are attached.

Ex. No.	Date	Age	HT.	FEV_1	FVC	MVV	FEV_1/FVC	Qualify
EX-1	0-17-04	50	66	2.11	2.99	59	70%	No
	(post-bronchodilator)			2.75	3.85	99	72%	No

The Claimant performed this study with "good effort" and understood the protocol. Dr. Rosenberg thought that the MVV was "severely reduced" because of "incomplete efforts." He recorded the following impression:

> No restriction. Mild to moderate obstruction. There was a definite bronchodilator response seen. The diffusing capacity corrected to lung volumes is normal indicating the alveolar capillary bed is intact. Air trapping is present.

EX-1.

Ex. No.	Date	Age	HT.	FEV_1	FVC	MVV	FEV_1/FVC	Qualify
EX-3	12-04-03	49	66.3	2.51	3.45		73%	No
	(post-bronchodilator)			2.39	2.92		72%	No

"Good" effort and cooperation were noted. Tracings are attached.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies are set forth at 20 C.F.R. § 718.105 (2004). A

Protopappas v. Director, OWCP, 6 B.L.R. 1-221 (1983). *See also Toler v. Eastern Associated Coal Corp.*, 43 F.3d 109, 114, 19 B.L.R. 2-70 (4th Cir. 1995).

"qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b) (2004).

The following arterial blood gas study evidence has been admitted into the record.

Ex. No.	Date	Physician	Alt.	pCO2	pO2	Qualify
DX-11	03-12-03	Mettu	--	38.8	58.5	Yes[6]
EX-1	06-17-04	Rosenberg	--	38.3	88.3	No[7]

Dr. Rosenberg thought that theses results were "normal" with an "increased" carboxyhemoglobin.

EX-3	12-04-03	Fino	--	34.8	79.7	No

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, and whether the miner is totally disabled. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. § 718.202(a)(4) (2004). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 C.F.R. § 718.202(a)(4) (2004).

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[6] The administrator of this test neglected to note the altitude. I take administrative notice that the elevation of Pikeville, Kentucky lies between 0-2,999' above sea level, with an elevation of 629 feet above sea level. *See* http://ukcc.uky.edu/~atlas/kyatlas?name=pikeville (Kentucky Atlas maintained by the University of Kentucky – site visited September 2, 2006).

[7] This study and the ABG test conducted by Dr. Fino produced non-qualifying results regardless of altitude.

Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b)(2)(iv) (2004). With certain specified exceptions, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 C.F.R. § 718.204(c)(2) (2004). Quality standards for reports of physical examinations are set forth at 20 C.F.R. § 718.104 (2004).

The claim record includes the following medical opinions.

Dr. R. V. Mettu

Dr. Mettu examined the Claimant on March 12, 2003 at the request of the Department of Labor. DX-11. He recorded a coal mine employment history of 25 years. The "patient history" included complaints of colds since 1995, attacks of wheezing for 20 years, chronic bronchitis of ten years duration and a heart attack in 1996. Claimant also suffered a collapsed lung in 1997 and a back injury ("3 disc") in 1995. Dr. Mettu also recorded a smoking history of 1/2 to one pack per day since 1980.

Present complaints included a daily cough productive of green sputum. Claimant also complained of daily bouts of wheezing, chest pain "while sitting and walking" and a nocturnal cough that had first become manifest five years before.

On physical examination, Dr. Mettu observed normal results of inspection, palpation, percussion and auscultation of the thorax and lungs. Examination of the extremities revealed no abnormalities. Current medications included "Trazadone, Xanax, Relafen, Lortab, Zocor" and an "arthritis pill." Dr. Mettu noted the results of a chest x-ray, which showed "no evidence of pneumoconiosis," and additional clinical tests such as a pulmonary function study, arterial blood gas test and an EKG.

Under "cardiopulmonary diagnosis," Dr. Mettu concluded that Claimant suffered from "chronic bronchitis," due to "working in coal mines and smoking." He also reported that Claimant suffered from the following non-cardiopulmonary diseases: ASHD, hyperlipidemia and arthritis. The doctor assessed a "mild pulmonary impairment" caused by "both working in coal mines and smoking."

Dr. David M. Rosenberg

Dr. Rosenberg examined Claimant for the Employer on June 17, 2004. He filed his report of this examination on June 29, 2004. EX-1.

Claimant told Dr. Rosenberg that he had been "placed on breathing treatments over the last three months" and that he had used Advair to good effect. Claimant told Dr. Rosenberg that he had become short of breath "walking in from the parking lot or climbing up any number of steps." The doctor also recorded complaints of wheezing and a productive cough. Claimant also described two-pillow othopnea and recalled that he would awakened by shortness of breath during the night. Claimant suffered a heart attack in 1996, and was being followed regularly by a cardiologist.

Claimant said that he had smoked from age 15 until the present time at the rate of 1/2 to 1 pack per day. He told Dr. Rosenberg that he had worked in the mines for 28 years, leaving in 1995 because he had injured his back in a mining accident. He described in detail his work duties as a miner-operator to Dr. Rosenberg. The doctor reported that towards the end of his career, the "miner was operated by [a] remote … control device, which weighed 10 to 15 pounds."

On physical examination of the chest, Dr. Rosenberg observed "expansion of the chest, without rales, rhonchi or wheezes, and [Claimant] had no murmurs, gallops or rubs." He also reviewed the results of clinical testing, including an arterial blood gas test, pulmonary function study, and chest x-ray.

Dr. Rosenberg summarized and discussed his results:

> [Claimant worked] in the coal mine industry over a period of nearly 28 years. All of his work was underground, and he described shortness of breath and is being treated for airways disease. He also has coronary artery disease and has been a chronic smoker. On examination his lungs were clear, and his pulmonary function test revealed a marked bronchodilator response to normal values. His TLC and diffusing capacity measurements were normal. His chest x-ray revealed clear lung fields.
>
> **DISCUSSION:** Based on a review of the above information, it can be appreciated that [Claimant's] lung volume measurements after bronchodilators are totally normal, indicating that he does not have restriction. In addition, on auscultation of his chest lung fields were clear and he did not have chronic end-inspiratory rales. It should also be appreciated that his diffusing capacity corrected for lung volumes was normal, which indicates that the alveolar capillary bed within his lungs is intact. Finally, on inspection of his chest X-ray he did not have interstitial

micronodularity of past coal dust exposure. Clearly, when all the information is looked at in total, [Claimant] does not have the interstitial form of coal workers' pneumoconiosis (CWP).

From a functional perspective, [Claimant] has mild airflow obstruction which normalizes after bronchodilators. Also, he has no restriction, with a normal diffusing capacity and PO2. Clearly, from a pulmonary functional perspective, he could perform his previous coal mine job duties or similarly arduous work. With his mild airflow obstruction normalizing after bronchodilators, he does not have COPD or any impairment related to past coal dust exposure. His airway disease relates to his long and continued smoking (carboxyhemoglobin level 6.4%).

In **CONCLUSION,** it can be stated with a reasonable degree of medical certainty that [Claimant] does not have CWP or associated impairment. He does not have respiratory disability and his reversible obstruction relates to smoking.

EX-1.

Dr. Rosenberg is board-certified in internal medicine, pulmonary disease and occupational medicine. He served as an Assistant Professor of Medicine at the Case Western Reserve University School of Medicine from 1979 until 1985, and since 1985 has been an Assistant Clinical Professor at that medical school. EX-6. He is also a B-reader. EX-2.

Dr. Gregory J. Fino

Dr. Fino examined Claimant on December 4, 2003 at the request of the Employer. He submitted his report of this evaluation on January 5, 2004. EX-3.

Dr. Fino reported that Claimant's only listed medication was an inhaler, and that he smokes cigarettes at the rate of one pack per day starting in 1969. The doctor recorded a coal mine employment history of 25 years in underground mining. He characterized Claimant's work in the mines as "heavy labor" while performing his last "classified job" as a continuous miner operator.

Claimant presented with a "breathing problem" of ten years duration characterized by worsening shortness of breath. Dr. Fino recorded that "[i]t does not interfere with [Claimant's] usual daily activities." He was also told that Claimant "becomes dyspneic when walking at his own pace on the level ground or ascending one flight of steps." Dr. Fino also reported under the "symptoms" section of the report that

"[d]yspnea does occur when walking up hills or grades, lifting and carrying, performing manual labor, and walking briskly on level ground." He further reported that "[Claimant] is limited in what he can do because of his breathing." While Claimant complained of a daily productive cough, he did not wheeze and did not complain of orthopnea or "paroxysmal nocturnal dyspnea."

On physical examination, Dr. Fino observed no "cyanosis, clubbing, or edema" of the extremities. The lungs were "[c]lear to auscultation and percussion on a tidal volume breath and a forced expiratory maneuver without wheezes, rales, rhonchi, or rubs." Dr. Fino also reviewed the results of clinical testing, including a negative chest x-ray, normal spirometry, lung volumes and oxygen saturation. The diffusing capacity was normal "after correction for alveolar volume." Claimant's carboxyhemoglobin level was "elevated."

Dr. Fino concluded that this was a "normal pulmonary examination." He discussed his results as follows:

> 1. … x-ray is negative for pneumoconiosis.
> 2. The acceptable spirometric evaluation is normal with no obstruction, restriction, or ventilatory impairment.
> 3. The diffusing capacity values are normal after correction for alveolar volume.
> 4. The TLC is not reduced and this rules out the presence of restrictive lung disease and significant pulmonary fibrosis.
>
> From a functional standpoint, this man's pulmonary system is normal. He retains the physiologic capacity from a respiratory standpoint to perform all the requirements of his last job. This assumes that his last job required sustained heavy labor. My reasons are as follows:
>
> 1. There is no ventilatory impairment as the normal spirometry clearly shows no evidence of obstruction, restriction, or ventilatory impairment.
>
> 2. The normal diffusing capacity rules out the presence of an impairment in oxygen transfer.

Dr. Fino concluded that there was "insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis." He found no respiratory impairment, and opined that "[Claimant] is neither partially nor totally disabled from returning to his last mining job or a job requiring similar effort." Dr. Fino emphasized that he would so conclude even assuming that Claimant suffered from pneumoconiosis.

EX-3.

Dr. Fino is board-certified in internal medicine with a sub-specialty in pulmonary disease. He is also a B-reader. EX-7.

Deposition Testimony

Dr. Rosenberg

Dr. Rosenberg's deposition testimony was recorded on October 7, 2004. EX-2. The questioning focused on Dr. Rosenberg's pulmonary evaluation. Counsel also inquired about the distinction between physical findings indicative of pneumoconiosis and those related to smoking. He testified that "[c]oal workers' pneumoconiosis generally would cause the presence of crackles or rales on listening or auscultation of the chest." This phenomenon would exhibit itself on inspiration. EX-2 at 7-8. According to Dr. Rosenberg, smoking would cause "airway conditions abnormalities on breathing out … [such as] rhonchi … or … wheezes[.]" EX-2 at 8.

When asked how "obstruction and restriction relate to coal worker's pneumoconiosis[,]" Dr. Rosenberg explained with respect to the latter:

> As far as obstructive lung disease. Coal Workers' pneumoconiosis can cause air flow obstruction and one looks for air flow obstruction … with CWP. Again that would not be an air flow obstruction that would improve after bronchodilators .... One looks at the x-ray findings and has to correlate the impairment assessment with the chest x-ray. The kinds of impairments that one sees with COPD related coal workers' pneumoconiosis is not the severe form of COPD that we see many times with negative or minimally abnormal chest x-rays that's not the kind of obstruction we see with CWP.
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> * * *
>
> [Coal worker's pneumoconiosis] clearly can cause air flow obstruction.

EX-2 at 14-15. He acknowledged that with an exposure history of 28 years in the mines, a miner "could develop various forms of medical pneumoconiosis … [o]ne could also potentially develop varying problems of obstructive lung disease, air flow obstruction … a whole variety of legal problems from coal workers' pneumoconiosis." EX-2 at 22.

Dr. Rosenberg discussed the clinical studies in light of those that were conducted by Drs. Mettu and Fino:

> He has mild airflow obstruction which was reversible at the time of my evaluation to normal. His blood gas studies had been down or reduced in the past. At the time of Dr. Mettu's evaluation was abnormal, but at the time of my evaluation had improved to normal. There was no increase in the A-a gradient or any abnormalities.
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> * * *
>
> [Noting the abnormal results recorded by Dr. Mettu] I'm talking about the time of my evaluation whatever was abnormal then which obviously his was a clearly abnormal blood gas, but whatever was there before has reversed to normal. More likely than not it had something to do with reversible airways disease … assuming the blood gas is valid that was normal.

EX-2 at 24. He questioned the reliability of Dr. Mettu's arterial blood gas study because it did not correlate with "everything else."

Dr. Rosenberg testified that he thought that results from clinical studies would not "wax and wane" if Claimant had pneumoconiosis. *Id.* He concluded that Claimant had neither clinical nor legal pneumoconiosis. EX-2 at 25.

On cross-examination, he acknowledged that pneumoconiosis can be a latent and progressive disease. EX-2 at 28. But Dr. Rosenberg also opined that "[a]s far as looking at the clinical situation with the pattern of impairments that I see now, I would say more likely than not if he deteriorated in the future, it would not be related to coal dust exposure." EX-2 at 29. He also acknowledged that coal workers' pneumoconiosis could coexist with a pulmonary disease that had a reversible component. EX-2 at 30.

Dr. Gregory J. Fino

Dr. Fino testified at a deposition recorded on March 30, 2004. EX-4. He stated that the Claimant's occupational history would be sufficient industrial exposure to cause a "susceptible individual" to contract coal workers' pneumoconiosis. EX-4 at 6.

Dr. Fino also recalled that he had recorded a smoking history of 34 pack/years. *Id*. Dr. Fino testified that one could expect from a smoking history of this nature the development of "emphysema, chronic obstructive bronchitis, chronic obstructive

pulmonary disease and lung cancer." He added that coal mine dust exposure would cause these abnormalities and "also cause pulmonary fibrosis or impairments in oxygen transfer."

The doctor elaborated on his examination of the Claimant, and questioning turned to the results of Dr. Mettu's clinical testing, most notably the qualifying arterial blood gas test which yielded a 58.5 pO2 result. Assuming that the study was valid, Dr. Fino opined that the hypoxemia illustrated by this result would not improve in the 9 month interval between Dr. Mettu's test and his own if that hypoxemia was due to the inhalation of coal mine dust. EX-4 at 9. He explained that pneumoconiosis is a progressive disease.

Dr. Fino concluded that the Claimant does not have pneumoconiosis, or any impairment or disability from a respiratory or pulmonary standpoint that he would relate to the inhalation of coal mine dust. He also thought that Claimant retains the respiratory capacity to return to his previous coal mine work. EX-4 at 10.

On cross-examination, Dr. Fino testified that only "15 percent of smokers develop a breathing impairment due to smoking[.]" EX-4 at 13. He opined that smoking has caused no respiratory impairment in this Claimant. *Id*.

DISCUSSION

Timeliness

Section 728.308 of the Secretary's regulations in part sets forth a rebuttable presumption that every claim for benefits is timely. 20 C.F.R. § 725.308. I find that this presumption has not been rebutted by evidence of record. The prescriptive periods of the Act, 30 U.S.C. § 932(a) and 20 C.F.R. § 725.308 would not have begun to run until after Claimant received notice that he was totally disabled due to pneumoconiosis. The Employer, while taking issue with the timeliness of this initial claim, has not explained how it is time-barred, and has not proffered evidence to rebut the presumption of timeliness. I therefore find that the instant claim is timely.

Responsible Operator and Related Issues

Employer has also contested its designation as responsible operator, and questions whether Claimant has any post-1969 employment.[8] I credit the employment history form and SSA earnings record to find that Claimant worked in the Nation's coal mines after 1969. Upon review of these documents, I also find that the district director has correctly designated J&S Collieries as the correct responsible operator, and that it is also self-insured. There is no showing that J&S Collieries does not meet the criteria for potential liability as responsible operator. *See* 20 C.F.R. § 725.495(c).

Pneumoconiosis

A claimant may demonstrate the existence of pneumoconiosis under any one of the alternate methods set forth at 20 C.F.R. §718.202(a). *See Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (en banc). There are four methods for determining the existence of pneumoconiosis. Under 20 C.F.R. § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. A Claimant may establish the presence of pneumoconiosis at Section 718.202(a)(2) upon the basis of autopsy or biopsy evidence. Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. The Secretary's regulations also provide that a miner may establish the existence of pneumoconiosis under Section 718.202(a)(4) on the basis of a medical opinion diagnosis of pneumoconiosis, notwithstanding a negative x-ray. 20 CFR § 718.202(a)(4).

20 C.F.R. § 718.202(a)(1)

The regulation at 20 C.F.R. § 718.202(a)(1) requires that "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays."[9] *See Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). Upon review of the x-ray evidence of record, I find that the

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[8] There is a "laundry list" of matters that have been checked in the Form CM-1025. It may well be that many of these issues would have been withdrawn had this claim gone to a formal hearing. Nevertheless, all issues have been considered.

[9] A "B-reader" (B) is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified" (BCR) denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

Claimant has not established the presence of pneumoconiosis at Section 718.202(a)(1). There are no x-ray interpretations that are positive for the existence of pneumoconiosis. In the final analysis, having conducted a "qualitative," as well as a quantitative evaluation of the x-ray readings, *see Woodward v. Director, OWCP*, 991 F.2d 314, 321, 17 B.L.R. 2-77 (6th Cir. 1993), I find that Claimant has not established pneumoconiosis at Section 718.202(a)(1) by a preponderance of the x-ray evidence.

20 C.F.R. § 718.202(a)(4)

There is no relevant biopsy or autopsy evidence, and the prerequisites for the application of Section 718.202(a)(3) do not apply. I therefore address the question of whether the Claimant has established the existence of pneumoconiosis on the basis of a reasoned medical opinion diagnosis of the disease. 20 C.F.R. § 718.202(a)(4). Three medical opinions pertaining to the existence of pneumoconiosis are in the record. Of these, only Dr. Mettu has diagnosed pneumoconiosis with his attribution of Claimant's "chronic bronchitis" in part to Claimant's coal mine dust exposure.

Pneumoconiosis under the Act is defined as both clinical pneumoconiosis and/or any respiratory or pulmonary condition significantly related to or significantly aggravated by coal dust exposure:

> (a) For the purpose of the Act, ''pneumoconiosis'' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or ''clinical'', pneumoconiosis and statutory, or ''legal'', pneumoconiosis.
>
> > (1) *Clinical Pneumoconiosis.* ''Clinical pneumoconiosis'' consists of those diseases recognized by the medical community as pneumoconioses, *i.e.,* the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
> >
> > (2) *Legal Pneumoconiosis.* ''Legal pneumoconiosis'' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

20 C.F.R. §§ 718.201(a)(1)-(2).

In *Cornett v. Benham Coal Co.*, 227 F.3d 569, 575, 22 B.L.R. 2-107 (6th Cir. 2000)., the court emphasized that the "legal" definition of pneumoconiosis "'encompasses a wider range of afflictions than does the more restrictive medical definition of pneumoconiosis.'" (quoting *Kline v. Director*, *OWCP*, 877 F.2d 1175, 1178, 12 B.L.R. 2-346 (3d Cir. 1989)). A finding that clinical pneumoconiosis has not been established does not preclude a finding of legal pneumoconiosis. *Cf. Consolidation Coal Co. v. Director, OWCP* [*Stein*], 294 F.3d 885, 892-93, 22 B.L.R. 2-409 (7th Cir. 2002) (negative CT scan does not rule out legal pneumoconiosis).

Although Dr. Mettu has diagnosed pneumoconiosis, his opinion is outweighed by the contrary opinions of Drs. Fino and Rosenberg, who have explained why Claimant's chronic obstructive pulmonary disease is not derived from his coal mine dust exposure. These experts have credibly demonstrated that Claimant's chronic bronchitis is not significantly related to or substantially aggravated by Claimant's coal mine dust exposure. *See Stiltner v. Island Creek Coal Co.*, 86 F.3d 337, 341, 20 B.L.R. 2-246 (4th Cir. 1996). *See generally* 65 Fed. Reg. 79943 (Dec. 20, 2000) (citing cases). For example, Dr. Rosenberg cited the normal lung volumes after the administration of a bronchodilator in the ventilatory test. Claimant had no restriction, and the mild airflow obstruction normalized after the use of the bronchodilator. He saw that the lungs were clear on physical examination. Dr. Fino observed no signs in his examination of the extremities - no cyanosis, clubbing or edema. The lungs were clear on auscultation and percussion. The pulmonary function testing showed no obstruction or restriction, and he noted that the diffusing capacity values were normal. Dr. Fino also cited the fact that the total lung capacity - TLC - was not reduced.

In crediting the medical opinions of Drs. Fino and Rosenberg, I have accounted for "the qualifications of the respective physicians, the explanation of their medical opinions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses." *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441, 21 B.L.R. 2-269 (4th Cir. 1997). *See Underwood v. Elkay Mining, Inc*., 105 F.3d 946, 950-951, 21 B.L.R. 2-23 (4th Cir. 1997). I also find that Employer's experts have adequately accounted for Claimant's lengthy coal mine dust exposure in rendering their opinions. *Cf. Peabody Coal Co. v. Hill*, 123 F.3d 412, 417, 21 B.L.R. 1-192 (6th Cir. 1997) (administrative law judge rejected opinions that failed to discount persuasively exposure effects of coal mine employment).

Because Claimant has not established pneumoconiosis under any provision set forth in Section 718.202(a), I find that he has not established this element of entitlement. On this basis, I find that he has not established entitlement to benefits under the Act. *Perry*.

Total Respiratory Disability

The Claimant must establish he is totally disabled due to pneumoconiosis in order to be eligible for benefits under the Act. *See Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304, or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR §§ 718.204(a), (b) and (c). I emphasize that *any* loss in lung function may qualify as a respiratory disability under Section 718.204(a). *See Carson v. Westmoreland Coal Co.*, 19 B.L.R. 1-16 (1964), *modified on recon*. 20 B.L.R. 1-64 (1996). Further, a "mild" pulmonary impairment may constitute a total respiratory disability if it is deemed to preclude the performance of the miner's usual coal mine work. *Cornett*, 227 F.3d at 578.

The Regulations provide a number of methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 C.F.R. §§ 718.204(b)(2) and (d) (2004). I must weigh all of the relevant probative evidence which meets one of the four medical standards applicable to living miners under Section 718.204(b)(2). *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986), *aff'd on recon.,* 9 B.L.R. 1-236 (1987)(*en banc*). In the absence of contrary probative evidence, evidence which meets one of the Section 718.204(b)(2) standards shall establish Claimant's total disability.[10] *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987).

20 C.F.R. § 718.204(b)(2)(i)

I find that the Claimant has not demonstrated total respiratory disability on the basis of the pulmonary function study results. The values achieved on the tests administered by Drs. Mettu, Fino and Rosenberg are uniformly non-qualifying.

20 C.F.R. § 718.204(b)(2)(ii)

I also find that, on balance, the arterial blood gas study results do not demonstrate total respiratory disability. Although the post-exercise results obtained by

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[10] Lay testimony may also constitute relevant evidence. *See Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122 (1999). A finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony, however. 20 C.F.R. § 718.204(d) (2002). *See Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994).

Dr. Mettu qualify, DX-11, the relevant blood gas study results at most are equally probative in view of the non-qualifying studies conducted by Drs. Fino and Rosenberg.

20 C.F.R. § 718.204(b)(2)(iii)

There is no evidence that the Claimant is afflicted with cor pulmonale with right-sided congestive heart failure. I therefore find that he has not demonstrated total respiratory disability at Section 718.204(b)(2)(iii).

20 C.F.R. § 718.204(b)(2)(iv)

I also find that total respiratory disability has not been demonstrated at Section 718.204(b)(2)(iv) on the basis of the medical opinion evidence.

Initially, I find that Dr. Mettu's finding of a "mild" impairment constitutes an assessment of a total respiratory disability. *See Cornett*. I credit Dr. Fino's characterization of Claimant's usual coal mine job as heavy labor, where Claimant operated a continuous miner and also had to lift heavy weight periodically throughout the day, and comparing Dr. Mettu's assessment with the requirements of the operator of a continuous miner, am satisfied that Dr. Mettu has concluded that Claimant is totally disabled.[11]

Nevertheless, I credit the contrary disability opinions from Drs. Fino and

[11] An important threshold issue is whether the Director has fulfilled the Department's statutory obligation to provide the Claimant with a complete pulmonary evaluation pursuant to Section 413(b) of the Act. 30 U.S.C. §923(b), as implemented by 20 C.F.R. §§ 718.102, 725.405 and 725.406. It is well-established that the Department of Labor has not satisfied this obligation if the physician who performed the pulmonary evaluation at the request of the Department has not addressed a necessary element of entitlement. *See Cline v. Director*, *OWCP*, 972 F.2d 234, 14 B.L.R. 2-102 (8th Cir. 1992); *Collins v. Director*, *OWCP*, 932 F.2d 1191, 15 B.L.R. 2-108 (7th Cir. 1991); *Newman v. Director*, *OWCP*, 745 F.2d 1161, 1166 (8th Cir. 1984). *See Hodges v. BethEnergy Mines Corp.*, 18 B.L.R. 1-84 (1994).

Upon careful evaluation of Dr. Mettu's conclusions, I am satisfied that his medical report satisfies the Director's obligation under Section 413(b). He rendered a cardiopulmonary diagnosis, and when asked to provide an assessment of impairment, Dr. Mettu opined that he suffered from a mild impairment. The disability assessment requested by the Department of Labor Medical Report Form is an assessment of the loss in pulmonary function. I find that this assessment adequately addresses the "disability" element of entitlement, and I draw the inference that Dr. Mettu has pronounced Claimant totally disabled from a pulmonary or respiratory standpoint.

Rosenberg. These physicians opined that Claimant suffers from no pulmonary or respiratory impairment. Dr. Fino, for example, was emphatic that even Claimant's smoking-related disease would not preclude him from returning to the mines. In the final analysis, and in view of the same factors as were set forth in the discussion of the medical opinion evidence at Section 718.202(a)(4), *see e.g. Akers*, I find that the opinions from Drs. Fino and Rosenberg preclude a finding of total disability at Section 718.204(b)(2)(iv). I recognize that, while a medical opinion may stand on its own at section 718.204(b)(2)(iv), *see Cornett*, the opinions of Employer's experts are better supported by the clinical documentation of record in the form of physical findings and non-qualifying clinical tests.

Fields – Shedlock Analysis

The final step is to determine whether the evidence establishes that the Claimant suffers from a totally disabling pulmonary or respiratory impairment. *See Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986), *aff'd on recon.,* 9 B.L.R. 1-236 (1987)(*en banc*). *See generally Poole v. Freeman United Coal Mining Co.*, 897 F.2d 888, 894, 13 B.L.R. 2-348 (7th Cir. 1990). Because the non-qualifying arterial blood gas tests, ventilatory tests, and the opinions from Drs. Fino and Rosenberg constitute contrary probative evidence, I am not persuaded by the medical opinion of Dr. Mettu, or the qualifying arterial blood gas study conducted by him, that Claimant has established total respiratory disability.

Because I find that Claimant has not established total respiratory disability, an element of entitlement, I find on this basis that he has not proven entitlement to benefits under the Act.

Disability Causation

Assuming that the Claimant has established that he suffers from pneumoconiosis and total respiratory disability, I nevertheless find that he has not proven disability causation. Benefits are provided under the Act for, or on behalf of, miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a) (2004). Pneumoconiosis must be a "substantially contributing cause" to the miner's total disability. 20 C.F.R. § 718.204(c)(1) (2004). The regulations define "substantially contributing cause" as follows:

> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
>
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. § 718.204(c)(1) (2004).

Upon review of the record as a whole, I find that the record does not establish the criteria for disability causation as set forth in the Secretary's regulations.

Because the Claimant has not established pneumoconiosis, total respiratory disability, or disability causation, I must find that he is not entitled to benefits under the Act.

ATTORNEY'S FEES

The award of an attorney's fee under the Act is permitted only in cases in which the Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim of D.R.S. for benefits under the Act is hereby DENIED.

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WILLIAM S. COLWELL
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used.

See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision